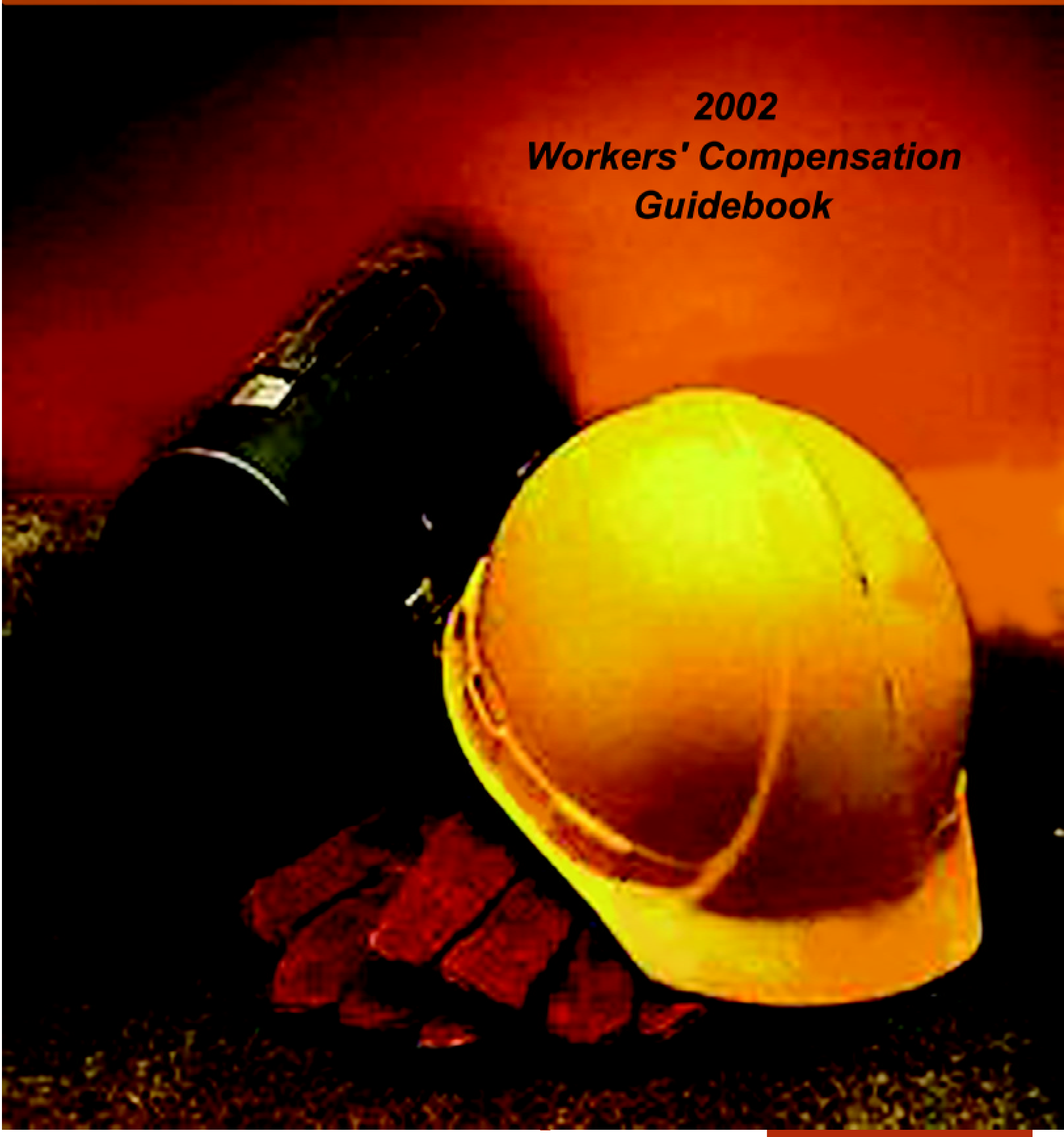
Kentucky Department of Workers' Claims



2002 Workers' Compensation Guidebook

Contacts

Commonwealth of Kentucky
Department of Workers' Claims
657 To Be Announced Avenue
Frankfort, KY 40601
http://labor.ky.gov/dwc

Commissioner
Larry M. Greathouse
502-564-5550 ext. 4421

Deputy Commissioner
Thomas "Tick" Lewis
502-564-5550 ext. 4412

Ombudsmen and Workers' Compensation Specialists'
Toll Free Numbers

Frankfort	800 554-8601
Louisville	866 874-0006
Madisonville	866 874-0005
Paducah	800 554-8603
Pikeville	800 554-8602
Frankfort Office:	502 564-5550

Agreements	Ext. 4551
Appeal Status	Ext. 4467
Claims Processing	Ext. 4534
Coverage Enforcement	Ext. 4450
EDI	Ext. 4540
Forms and Publications	Ext. 4568
Insurance Coverage	Ext. 4448
Managed Care	Ext. 4449
Medical Schedulers	Ext. 4445
Open Records	Ext. 4429
Self Insurance Coverage	Ext. 4411
Statistical Data	Ext. 4423
Vocational Rehabilitation	Ext. 4544
Web site	Ext. 4437

NOTE: This guidebook contains only limited summaries of Kentucky's Workers' Compensation Law. The complete law is in Chapter 342 of the Kentucky Revised Statutes and in Chapter 25 of Title 803 of the Kentucky Administrative Regulations. For information on receiving copies of the law, call 1-800-554-8601.

Letter from the Governor

Dear Fellow Kentuckians:

The Kentucky workers' compensation program was founded upon the promise that employees who were disabled by on-the-job accidents would receive wage replacement benefits and medical treatment. Over the decades, a large and complex workers' compensation system has evolved; some changes to the law have been minor, others have been significant.

The changes made during this past session of the General Assembly broadening black lung benefits for coal miners are specially featured in this updated *Guidebook to Workers' Compensation*. Keeping the promise that I made in my State of the Commonwealth Address, this new law offers increased benefits to injured or impaired coal miners.

Our goal in distributing this guidebook is to explain in understandable terms the workers' compensation law, the rights and responsibilities of all involved and what procedures should be followed when an injury occurs.

Through the efforts of our Labor Cabinet, safety issues are addressed and training programs are offered in our attempts to prevent work-related injuries and illnesses. The role of the Department of Workers' Claims is to assist those workers who do become injured or ill. We hope that this guidebook serves as a valuable tool for the workers, the employers and the workers' compensation insurance carriers of the Commonwealth.

Sincerely,

Paul E. Patton
Governor

Joe Norsworthy
Secretary of Labor

Kentucky Labor Cabinet Mission Statement

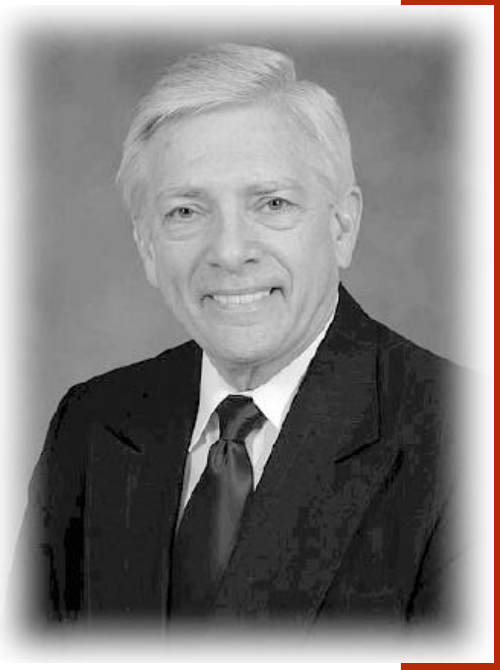
Our mission is to administer Kentucky's workplace standards and workers' compensation laws through education, mediation, adjudication, and enforcement in order to promote safe, healthful, and quality working environments for employees and employers; to foster cooperative relationships between labor and management; and to ensure fair compensation.

Kentucky Department of Workers' Claims Mission Statement

Resourceful administration of Kentucky's workers' compensation program and equitable and expedient processing of claims.

- To assure prompt delivery of statutory benefits, including medical services and indemnity payments
- To provide timely and competent services to stake holders
- To foster stakeholder knowledge of rights and responsibilities under the Workers' Compensation Act
- To encourage stakeholder involvement in the development of policy and delivery mechanisms
- To provide the public and policy makers with accurate and current indicators of program performance
- To anticipate changes in the program environment and respond appropriately

Letter from the Commissioner



Message from the Commissioner:

This Guidebook to Workers' Compensation is intended to assist workers, employers and insurance representatives in understanding the workers' compensation program in the Commonwealth of Kentucky.

We have designed this in an effort to answer many of the most frequently asked questions concerning rights and responsibilities and the processes involved under the Workers' Compensation Act.

Our hope is that understanding the system will ease some of the anxiety of both employees and employers as it relates to injuries and workers' compensation claims.

Additional information concerning the workers' compensation program, the latest regulations and approved forms can be found on our web site:

http://labor.ky.gov/dwc

As always, our staff members are available to assist you with any questions or concerns you may encounter.

Sincerely,

Larry M. Greathouse
Commissioner

Department of Workers' Claims

Table of Contents

Table of Contents

Program Overview

The General Assembly establishes rights and duties regarding workers' compensation through Chapter 342 of the Kentucky Revised Statutes, the *Workers' Compensation Act.*

In Kentucky, it is the Department of Workers' Claims within the Labor Cabinet that administers the workers' compensation program. The Commissioner of the Department of Workers' Claims is appointed by the Governor to adopt regulations that guide the claims process and the delivery of medical and vocational rehabilitation benefits.

Goals and objectives of the Department of Workers' Claims include:

- Provide information concerning benefits;
- Assist informal resolution of disputes;
- Maintain records of injuries and program costs;
- Process and adjudicate claims;
- Enforce laws requiring employer coverage;
- Regulate self-insured employers;
- Implement strategies to improve carrier performance;
- Render program assessment to policy makers.

Kentucky's Workers' Compensation Act provides certain benefits to employees injured in job-related accidents and to those who contract or develop diseases due to workplace exposure.

In Kentucky, workers' compensation is considered the "exclusive remedy" for injured workers. This means that in exchange for the protection that workers' compensation coverage offers, employees surrender their right to sue employers in civil court for damages arising from workplace injuries.

Workers' compensation benefits include partial wage replacement, payment of medical treatment and new job training.

If an employee's death occurs as a result of the injury, a lump sum payment is made to the employee's estate, from which burial expenses are to be paid. Income benefits are also extended to the surviving spouse and dependents. The amount of the lump sum payment changes annually.

Many workers' compensation disputes are resolved when the parties agree to a compromise settlement. However, if such a settlement can not be reached, it is necessary for the parties to litigate the claim. This process is begun when an application for adjustment of the claim is filed with the Department of Workers' Claims by the employee or employer. The Department issues an order assigning the case to an Administrative Law Judge, and scheduling a benefit review conference. This order also

contains a time schedule to allow the parties to file medical documents and evidence in the case.

The Benefit Review Conference is an informal proceeding held before the Administrative Law Judge. It gives the parties the opportunity to discuss the strengths and weaknesses of the case, with the goal of settling it at that time. The Administrative Law Judge also has the opportunity to participate, and rule on any procedural disputes.

If the claim is not settled at this point, the Administrative Law Judge schedules a formal hearing, which is typically held two weeks later. This hearing is the opportunity for the employee and employer to testify in the presence of the Administrative Law Judge. A court reporter is present, and makes a complete record of that testimony. Within sixty days after that hearing, the Administrative Law Judge issues a decision in the case, awarding or denying income and medical benefits and possibly rehabilitation benefits. That decision is based upon the evidence offered by all of the witnesses, the medical reports filed by the parties, and is controlled by the Workers' Compensation statute and case law. The Administrative Law Judge can not order an employer to pay income benefits in a lump sum. Such payments only occur when the parties all agree to that arrangement and the Administrative Law Judge approves it.

Any party who disagrees with the decision of the Administrative Law Judge (ALJ) may file an appeal to the Workers Compensation Board (WCB). An appeal is a review of the ALJ's decision and determines whether the ALJ erred in applying the law to the facts of the case. An appeal is not an opportunity to submit new or additional evidence. On appeal, the ALJ's factual findings will not be changed unless there is no evidence to support the ALJ's decision. Any party who disagrees with the decision of the Workers Compensation Board may appeal to the Kentucky Court of Appeals, and then to the Supreme Court of Kentucky.

.

Department of Workers' Claims
657 To Be Announced Avenue
Frankfort Kentucky 40601

Who is covered by the Act?

Most Kentucky employers are subject to the Workers' Compensation Act and are required to carry workers' compensation insurance or become self-insured, even if they have only one part-time employee. There is an exemption for employers engaged exclusively in agriculture.

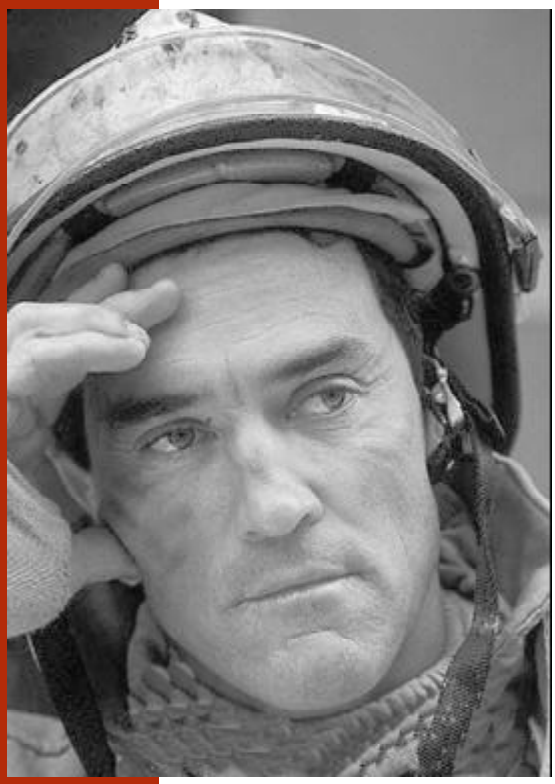
State law requires employers to *'conspicuously post'* a Workers' Compensation Notice, stating the name of its workers' compensation insurance carrier and policy number. Providing every employee the opportunity to become informed about their employer's workers' compensation program, the notice should also contain information about what an employee is to do when injured.

For information on how to determine if an employer is covered by workers' compensation insurance, call the Department of Workers' Claims at 1-800-554-8601.

Who else is covered?

Every person who is a member of a volunteer ambulance service, **fire** or **police** department shall be considered an employee of the political subdivision of the state where that department is organized.

Every person who is a regularly enrolled **volunteer member** or **trainee** of an **emergency management agency**, as established under KRS chapters 39A to 39E, shall be considered an employee of this state.



Every person who is a **member** of the **Kentucky National Guard**, while that person is on state active duty as defined in KRS 38.010 (4), shall be considered to be in the employment of the state. "Kentucky National Guard" includes the Army National Guard and Air National Guard.

Who is not covered?

Some employees are exempt from mandatory workers' compensation coverage. Some of these exemptions include farm workers and workers employed as domestic servants in a home with less than two full-time employees. Also exempt is any person employed by homeowners for residential maintenance and repair for up to twenty (20) consecutive workdays.

Additionally, employees who are protected by federal laws (such as railroad and maritime workers) and members of certain religious sects are exempt from coverage under the Workers' Compensation Act. Business owners are not required to obtain coverage for themselves, but are not covered unless they specifically purchase workers' compensation coverage for themselves.

Can I waive coverage?

Another example of employees who are not covered by workers' compensation insurance coverage are those who voluntarily sign a waiver of workers' compensation protection. Employees may reject coverage under the Workers' Compensation Act by signing and filing with the employer an Employee's Notice of Rejection of Workers' Compensation Act, commonly known as a Form 4 Waiver.

The law prohibits employers from requiring employees to sign a Form 4 Waiver as a condition of employment. Only waivers that are signed freely by employees — that is, when there is no pressure to do so — are to be upheld. The law requires that employers file all waivers from employees with the Department of Workers' Claims in order for the waiver to be in force.

By rejecting the Act, employees surrender benefits they may be due under the Workers' Compensation Act, but retain the right to sue employers for work-related injury or disease in civil court. Unlike the workers' compensation process, a suit in civil court requires proof of negligence or wrongdoing on the employer's part in order to obtain damages.

Business partners who are owners of a business are not required to obtain workers' compensation coverage on themselves. However, partners must file a copy of the partnership agreement with the Department of Workers' Claims. Without evidence of ownership, workers will be treated as employees subject to coverage.

What if I'm an independent contractor?

Whether a worker is an employee or an independent contractor is a frequently disputed issue in workers' compensation claims. Four main factors are considered: the nature of the work performed as it relates to the business of the possible employer, the extent of control of details of the work, the professional skill of the worker and the intentions of the parties. Generally, an independent contractor, as a skilled tradesman, works on his/her own without direct supervision, setting work hours and providing the needed tools and equipment for the job.

Who is responsible for temporary employees?

Employee leasing corporations must register with the Department of Workers' Claims and demonstrate that workers' compensation coverage has been secured for job sites where leased employees work. Temporary help service companies are considered employers of temporary employees and must have workers' compensation insurance coverage.

Information concerning employee leasing is available by calling the Department of Workers' Claims Coverage branch at 502-564-5550, ext. 4448.

Who is responsible for benefit payments?

The Department of Workers' Claims does not pay benefits. Employers are responsible for payment of benefits due under the Workers' Compensation Act. Usually, this liability is insured through workers' compensation insurance.

The law imposes penalties on employers who fail to obtain workers' compensation coverage. Businesses with no coverage may be closed by court action and uninsured employers are subject to civil suits when a workplace injury occurs. Citizens are urged to report uninsured employers to the Department of Workers' Claims by calling 1-800-554-8601.

What is a work related injury?

The purpose of workers' compensation insurance is to provide benefits to injured workers for workplace injuries and occupational diseases. Through the statutory definition of injury, the legislature describes those injuries that are recognized as qualifying for compensation under the workers' compensation law. Common legal phrases used are that the injury is "work-related" or that it "arises out of and in the course of employment".

KRS 342.0011 reads "Injury means any work-related traumatic event or series of events, including cumulative trauma, arising out of and in the course of employment which is the proximate cause producing a harmful change in the human organism evidenced by objective medical findings."

Current law also states that "injury does not include the effects of the natural aging process and does not include communicable diseases unless the risk of contracting the disease is increased by the nature of the employment".

Employees are clearly entitled to benefits if injured while performing normal duties during regular working hours. Often, questions arise if employees are injured in circumstances that are not typical of the normal working environment in terms of time, place or performance of duties. Workers' compensation is generally not allowed for injuries resulting from horseplay, intentional self-infliction, intoxication or injuries incurred while traveling to and from work.

What is an occupational disease?

Occupational diseases are covered by the workers' compensation law. An occupational disease is a condition caused by an exposure to a hazard in the workplace and usually develops over a period of time.

The employer where the worker was last exposed to the hazards of the disease is the employer responsible for payment of benefits. Generally, a physician's opinion is required to establish that the injury or disease is causally connected to the work.

The most common occupational disease in Kentucky is coal workers' pneumoconiosis (CWP), often called black lung. This disease is caused by the prolonged breathing of coal dust. Black lung claims are subject to special statutory rules and requirements (see page 28).

Is an employee covered if the injury is a result of an intentional violation of safety laws or regulations?

Although benefits are granted even if an employee's mistake or carelessness caused the accident, disability payments may be reduced by 15% in cases where the worker's intentional violation of a safety law or regulation caused the injury.

Likewise, if the employer's intentional violation of a safety law or regulation caused an injury, a safety penalty may be imposed against the employer. KRS 342.165 allows for the income benefits of an injured worker to be increased by 30% if the injury was caused by a violation of a safety law or regulation by the employer.

As an injured employee, what are my rights under the Kentucky workers' compensation law?

As an employee in Kentucky, you have the right to:

- Workers' compensation insurance coverage. This coverage should be furnished by your employer at no cost to you.
- Know the identity of the workers' compensation insurance carrier and the claim representative.
- Receive a courteous and reasonably prompt response from the carrier upon communication regarding a claim.
- Receive temporary income benefits while recuperating from the injury.
- Receive all necessary medical treatment for the occupational injury or disease without making a co-payment.
- Select a physician to treat a work related injury or illness without interference from your employer.
- Change the treating physician one time with no questions asked.
- Receive a card, which identifies the designated physician, employer and carrier.
- Be reimbursed for expenses paid in the process of receiving medical treatment, including travel expenses and out of pocket payment of prescription medications.
- Receive retraining if unable to return to suitable work.
- File a claim for permanent disability benefits within two years of the injury or the termination of temporary income benefits, whichever is later.

As an injured employee what are my responsibilities under the Kentucky workers' compensation law?

As an injured employee you must:

Notify Supervisors of Injuries and Diseases.
Employees must immediately (or "as soon as practicable") notify their supervisors of any injury. Notification should include information about the work occurrence and the body part affected. Most employers have a written policy for reporting injuries; compliance with that policy will facilitate the payment of benefits.

A claim may involve an occupational disease or gradual injury that is not readily viewed as being caused by work. In these circumstances as soon as an employee learns a condition may be work-related, notice should be given to the employer. Often employees acquire this knowledge from a physician who advises of the work connection.

Obtaining Medical Services.
As soon as possible after the work-related injury occurs, the employee should obtain necessary medical services. The employee may choose the treating physician and can change that selection one time, no questions asked. If the employer has entered into an authorized managed care program, the employee must choose from among the participating medical providers. Employees must notify the employer and insurance carrier of the physician choice. The employer or insurance carrier should deliver to the employee a physician designation and identification card once it is known that the employee requires continuing medical care.

Employees should ask treating physicians to promptly report their status to the employer and insurance carrier. Prompt reporting speeds payment of benefits and helps employers and physicians in assisting employees to return to work.

Maintaining Open Lines of Communication.
In addition to promptly reporting injuries and medical status to employers, employees should keep lines of communication with the employer open.

Generally, the employer is interested in the well being of the employee and wants workers' compensation benefits extended until the employee can return to work.

As the employer of an injured worker what are my responsibilities?

Employers who are not exempt from the Workers' Compensation Act must obtain workers' compensation insurance, post a notice showing insurance coverage and report injuries to the insurance carrier. Employers should communicate with employees after an injury and attempt to informally resolve conflicts with employees. Model employers have created programs to return employees to work as soon as possible after injury.

Once insurance coverage is obtained, the carrier must provide the employer with a notice to post at the principal personnel office of the employer. The notice shall include all pertinent workers' compensation insurance information such as the name of the carrier, the policy number, a contact name and telephone number that can be accessed by injured employees. New posting requirements for coal mine employers are required by the 2002 black lung law effective 7-15-02. A notice must be posted displaying the educational and retraining opportunities provided under the law if a miner contracts CWP. Notices for posting may be obtained from DWC.

How does an employer obtain insurance and how are premium charges calculated?

Employers obtain workers' compensation coverage either through purchase of a policy from an insurance carrier or by joining a self-insurance group.

The amount an employer pays as premium to secure workers' compensation insurance is dependent upon the industrial job classifications of the employer, the amount of payroll, and the loss history of that employer. Good workplace safety practices, modified duty programs for injured employees, and a managed care program to deliver necessary medical services reduce workers' compensation losses.

Who is responsible for reporting proof of coverage?

Workers' compensation insurance companies are required to electronically file with the Department of Workers' Claims on behalf of the employer proof that the employer has obtained workers' compensation insurance coverage. In addition, the insurance carrier shall immediately notify the Department of Workers' Claims of any cancellation, termination or lapse in the coverage.

What is self-insurance?

Major employers may qualify to become individually self-insured by demonstrating financial soundness to the Department of Workers' Claims. Self-insured employers pay their own workers' compensation losses directly and do not carry primary insurance coverage.

Employers may join together and form associations known as self-insurance groups to insure member workers' compensation liability. Self-insurance groups may offer a lower premium than that available from insurance carriers. To obtain coverage from a self-insurance group, an employer must be a group member and must agree to be liable for assessments that may be necessary to pay the group's workers' compensation losses.

To maintain self-insurance certificates, self-insured groups and individually self-insured employers must be members of a guaranty fund. Guaranty funds will help meet obligations should a self-insured employer or self-insured group become insolvent.

Who is responsible for reporting injuries to the Department of Workers' Claims?

Kentucky law holds the workers' compensation insurance carrier responsible for compliance with reporting requirements. Insurance carriers and self-insured employers are required to report to the Department of Workers' Claims any injury that causes an employee to miss more than one day of work.

Electronic Data Interchange (EDI) is the method of reporting workers' compensation activity to the Department of Workers' Claims as required by law. The report shall be filed electronically through an approved trading partner and must be made within one week of the carrier receiving notice of injury from the employer.

In addition to First Reports of Injury, carriers and self-insured employers must also file Subsequent Reports of Injury. These supplemental reports cover an injured worker's return to work, payment of temporary disability benefits and settlements.

If an injured workers' Temporary Total Disability extends for a period of 60 days, the carrier/self-insured employer must submit a supplemental report. Within one week of Temporary Total Disability benefits being terminated, changed or resumed, the carrier /self-insured employer must notify the Department of Workers' Claims.

What are the responsibilities of the insurance company's claims management staff?

The claims management and settlement practices of insurance carriers are closely monitored by the Department of Workers' Claims. All carriers have certain duties and responsibilities once an injury has been reported. These include the duty to:

- Diligently investigate a claim for facts warranting the payment or denial of benefits;
- Advise in writing to the injured employee acceptance or denial of the claim as soon as practicable or inform the employee of the need for additional information;
- Meet the time constraints for accepting and paying workers' compensation claims;
- Attempt in good faith to promptly pay a claim where liability is clear;
- Make a prompt and appropriate reply to the employee and the Department of Workers Claims upon inquiry;
- Maintain claim records that show the basis of claims management decisions.

What should the insurance company avoid?

The insurance company should not:

- Misrepresent pertinent facts or law with regard to a claim;
- Offer a settlement which is substantially less than the reasonable value of a claim;
- Threaten to file or revoke a policy or filing appeals for the purpose of compelling a settlement for less than a workers' compensation award or benefit review determination;
- Require an employee to obtain information which is accessible to the carrier;
- Compel an injured worker to initiate legal proceedings to recover benefits where liability is clear.

Are penalties ever assessed against an insurance company?

The Department of Workers' Claims acts swiftly to investigate allegations that an insurance carrier has committed an unfair claims settlement practice. If a violation is found, the Commissioner may issue penalties against the carrier ranging from $1,000 to $5,000 per offense. If there appears to be a pattern of violations, the Commissioner of the Department of Workers' Claims may revoke the certificate of self-insurance or request the Commissioner of Insurance to revoke the certificate of authority of the insurance carrier.

Any suspected violations may be reported to the Commissioner's office, or through the Ombudsmen/Specialists toll-free number: 1-800-554-8601.

How do you report suspected fraud?

It is unlawful to knowingly file or permit to be filed any false or fraudulent claim to obtain workers' compensation benefits. Likewise, it is unlawful to misrepresent important facts to avoid responsibility under the law.

Incidents of suspected fraud should be reported to a Department of Workers' Claims ombudsman or specialist at 1-800-554-8601. Through its Insurance Fraud Investigation Division, the Department of Insurance actively investigates and prosecutes workers' compensation insurance fraud.

Benefits

If an injury occurs, what kind of benefits are paid?

Worker's compensation law recognizes three types of disability — **temporary total**, **permanent partial** and **permanent total** — and establishes disability income benefit payments for each type.

How much are the benefit amounts?

Disability percentages are determined by the American Medical Association impairment rating that is then multiplied by factors established by law.

Disability benefit payments depend upon the employee's average weekly wage and on the extent of disability stated in a percentage. A number of special rules govern the determination of the average weekly wage applicable to an injury. KRS 342.140 outlines the computation based on how a worker is paid (if wages are fixed by the hour, day, the week or the month).

In most instances, an employee's average weekly wage is calculated by using the highest wages paid during a 13-week period in the year before the injury occurred. Overtime is included, but only at regular hourly wage rates. These earnings for the highest quarter are then divided by 13 and the result is the employee's average weekly wage.

Who qualifies for Temporary Total Disability benefits?

Temporary total disability (**TTD**) benefits are paid to the employee who is recovering from an injury or disease and is unable to return to work. Once the disabled worker has been unable to work for more than seven (7) days, he/she is entitled to TTD benefits for each day thereafter.

If the disability exceeds two (2) weeks of lost time from work, the employee is then entitled to payment of benefits for the first seven (7) days.

Kentucky law makes no allowance for temporary partial disability benefits (payment to an injured worker who returns to work but is earning less than their pre-injury weekly wage).

Usually, in cases of severe injury, TTD benefits are voluntarily paid by the insurance company of the injured worker's employer. Payment of TTD benefits ends when the employee recovers sufficiently to be able to return to work or when a physician reports that an employee has reached maximum medical improvement. It may be restarted if the employee finds, upon returning to work, that he/she is unable yet to do the work, or must stop work for surgery or other medical treatment.

How are Temporary / Permanent Total Disability benefit payments calculated?

Weekly benefit payments for total disability are two-thirds (2/3) of the employee's average weekly wage, but no more than the state's average weekly wage. For example, a worker who had an average weekly wage of $350 would receive $233.33 per week in total disability benefit payments. The state's average weekly wage is announced annually by the Cabinet for Workforce Development and actually represents the state average weekly wage of two years ago.

Who qualifies for Permanent Total Disability benefits?

Permanent total disability benefits (**PTD**) are payable when "an employee...has a complete and permanent inability to perform any type of work as a result of an injury."

Permanent total disability benefits are paid when the worker is so severely injured that he/she cannot obtain and maintain a job. These benefits are not awarded until after the worker has reached maximum medical improvement. This means the physical condition of the employee has stabilized and no significant improvement is expected in the future.

Also, according to workers' compensation law, total disability shall be presumed to exist for an injury that results in:

1. total and permanent loss of sight in both eyes,
2. loss of both feet at or above the ankle,
3. loss of both hands at or above the wrist,
4. loss of one foot at or above the ankle and loss of one hand at or above the wrist
5. permanent and complete paralysis of both arms, both legs, or one arm and one leg,
6. incurable insanity or imbecility, or
7. total loss of hearing.

The maximum allowable weekly benefit was $509.03 for injuries occurring in 2000 and $530.07 for injuries occurring in 2001. For the year 2002, the state's average weekly wage is $550.66.

Benefits are paid as long as total disability continues, but are subject to offsets and/or termination, which is explained in more detail on page 26. Also, permanent total disability benefit payments may be reduced if it is shown that the injured worker has recovered sufficiently to return to work.

Who qualifies for Permanent Partial Disability benefits?

Permanent partial disability benefits (**PPD**) are payable when "an employee...has a permanent disability rating but retains the ability to work". The term **permanent** refers to **a physical disability** expected to last into the future. Use of the word "permanent" does not describe the period of payment; payment for partial disability is limited, usually to 425 weeks.

Expressed as a percentage, a *permanent disability impairment rating* means the percentage of whole body functional impairment caused by the injury or occupational disease. This is determined by the treating physician using a publication called the American Medical Association's *Guides to the Evaluation of Permanent Impairment* as the basis. The law establishes use of this book as the means by which disability ratings are given under workers' compensation.

How are Permanent Partial Disability benefits calculated?

The amount and duration of benefits is usually controlled by the law on the date the injury occurs. Due to periodic changes in the law, the date of the injury generally will determine benefit entitlement.

The maximum benefit for permanent partial disability is 75% of the state's average weekly wage — $381.77 for 2000 and $397.55 for 2001. For the year 2002, the maximum weekly benefit payment is $413.00. There is no minimum benefit.

Recognizing that limited education and advancing age impact an employee's after injury earning capabilities, special consideration such as education and age factors can be added to the income benefits.

If an employee does not retain the "physical capacity" to return to the type of work performed at the time of the injury, the weekly benefit is increased. If the employee returns to work at the same or greater wages, but at some point ceases to work, payment of weekly benefits increases, doubling or tripling, depending on the law in effect on the date of injury.

Injuries occurring between December 12, 1996 and July 13, 2000

When an injured worker improves enough to return to work, but still has a permanent impairment (as determined by the *AMA Guides to Evaluation of Permanent Impairment),* permanent partial disability benefits (PPD) are available.

The number of payments depends on the disability rating. With an impairment rating of 50% or less, benefit payment will extend to 425 weeks; 520 weeks for an impairment rating that is greater than 50%. The amount of benefit payments also depends on the impairment rating, which is then multiplied by a factor. This factor is established by law and subject to change.

AMA Impairment Rating	Factor
0-5%	0.75
6-10%	1.00
11-15%	1.25
16-20%	1.50
21-25%	1.75
26-30%	2.00
31-35%	2.25
36% and above	2.50

To determine the extent of permanent partial disability benefits, use the example of an injured worker has recovered enough to return to work, but has a 15% impairment rating. The impairment rating of 15% is multiplied by a factor of 1.25 which equals 18.75%. Since this worker's disability rating is less than 50%, the disability benefit payments will extend for 425 weeks.

With an AMA functional impairment rating of 15% and an average weekly wage of $350, this injured worker will receive $43.75 in weekly permanent partial disability benefit payments.

$350 x 66.67% = 233.33
$233.33 x 15% (AMA impairment rating) = $35.00
$35.00 x 1.25 (Factor) = $43.75 per week

If this worker does not retain the physical capacity to return to the type of work performed at the time of injury, the weekly disability payment is multiplied by 1.5 and will be:

$43.75 x 1.5 = $65.63

If this worker returns to work at the same or at greater wages, weekly disability benefit payments will be reduced by on half and will be:

$43.75 x 50% = $21.88

Injuries occurring on or after July 13, 2000

When an injured worker improves enough to return to work, but still has a permanent impairment (as determined by the AMA Guides to Evaluation of Permanent Impairment), permanent partial disability benefits (PPD) are available.

The number of payments depends on the disability rating. With an impairment rating of 50% or less, benefit payments will extend to 425 weeks; 520 weeks for an impairment rating that is greater than 50%. The amount of benefit payments also depends on the impairment rating, which is then multiplied by a factor. This factor is established by law and subject to change.

AMA Impairment Rating	Factor
0-5%	0.65
6-10%	0.85
11-20%	1.00
21-25%	1.15
26-30%	1.35
31-35%	1.50
36% and above	1.70

To determine the extent of permanent partial disability benefits, suppose an injured worker has recovered enough to return to work, but remains permanently impaired, which is rated at 15%. The impairment rating of 15% is multiplied by a factor of 1.00 which equals 15.00%. Since this worker's disability rating is less than 50%, the disability benefit payments will extend for 425 weeks.

With an AMA functional impairment rating of 15% and an average weekly wage of $350, this injured worker will receive $35.00 in weekly permanent partial disability benefit payments.

$350 x 66.67% = 233.33
$233.33 x 15% (AMA impairment rating) = $35.00
$35.00 x 1.00(Factor) = $35.00 per week

If this worker does not retain the physical capacity to return to the type of work performed at the time of injury, the weekly disability payment is multiplied by 3 and will be:

$35.00 x 3= $105.00

If the employee returns to work at an equal to or greater wage and at some point there is an interruption in that employment, the weekly benefit will be multiplied by two during the period of unemployment.

If the employee returns to work at an equal to or greater wage, no multiplier will be added

Are age at the time of injury and education level factors in determining Permanent Partial Disability Benefit Payments?

Limited formal education and advancing age at the time of injury will increase permanent partial disability benefit payments for injuries occurring on or after July 14, 2000.

The amount of benefit payments depends on the impairment rating and on a multiplier of 3, which is established by law and subject to change.

Limited education is assigned two separate values to be added to the multiplier of 3. If an employee has less than eight years of formal education or a GED diploma, the multiplier is increased by 0.2.

Depending on the age of the employee at the time of injury, the multiplier will be increased as the chart indicates:

Age at time of injury	Multiplier Increase
49 or less	0
50-54	0.2
55-59	0.4
60 or older	0.6

To determine the extent of permanent partial disability benefits, suppose an injured worker has recovered enough to return to work, but remains permanently impaired, which is rated at 15%. The impairment rating of 15% is multiplied by a factor of 1.00 which equals 15.00%. Since this worker's disability rating is less than 50%, the disability benefit payments will extend for 425 weeks. Suppose also that the age of the worker is 57 and the worker has 11 years of education.

Based on the values added for limited education and the age at the time of injury chart above, the multiplier 3 will be increased by 0.4 for age and 0.2 for education.

With an AMA functional impairment rating of 15% and an average weekly wage of $350, this injured worker will receive $126.00 in weekly permanent partial disability payments.

$350 x 66.67% = 233.33
$233.33 x 15% (AMA impairment rating) = $35.00
$35.00 x 1.00(Factor) = $35.00 per week

$35.00 x 3.6 = $126
(3 is multiplier 0.4 is added for age, 0.2 is added for limited education)

If a worker is receiving other insurance benefits, are workers' compensation benefit payments affected?

Workers' compensation benefits paid for temporary total and permanent total disability will be reduced if the injured worker is also receiving unemployment insurance payments during the period of disability.

Likewise, workers' compensation benefits paid for temporary total and permanent total disability may be reduced if the injured worker is receiving payments from a disability or sickness and accident insurance plan which was purchased by the employer.

What happens to benefit payments when the injured worker reaches retirement age?

For those workers whose **injuries occurred between April 4, 1994, and December 11, 1996,** income benefit payments are reduced by 10% when the worker reaches age 65 extending through age 70. At the end of this "tier-down" of benefits, the employee retains 40% of the original award.

When and why are workers' compensation benefit payments terminated?

If an injured worker unreasonably refuses medical treatment, income benefit payments may be terminated even if the employee remains disabled. Benefit payments may also be discontinued if the injured worker fails to appear for scheduled independent medical examinations or refuses to be questioned at depositions or hearings.

For injuries occurring on or after **December 12, 1996**, income benefit payments for permanent partial disability will terminate when the injured worker qualifies for normal Social Security benefits, or two years after the injury or last exposure, whichever occurs last.

Income benefit payments to dependent children of a deceased worker will terminate when the child reaches the age of 18. If the child is still in school, benefit payments will cease at the completion of schooling or when the dependent reaches the age of 22 unless child is incapable of self support.

Does a claim have to be filed before income benefits are paid?

Most injuries requiring payment of workers' compensation benefits are resolved by a settlement before a claim is filed. The **Agreement as to Compensation and Order Approving Settlement** form is signed by the employer and the injured worker and then sent to the Department of Workers' Claims, where it must be approved by an Administrative Law Judge.

Settlements may include payment in a lump sum – instead of receiving weekly benefit payments for a fixed number of weeks, the injured worker can agree with the employer's insurance carrier to receive one payment right away. This is voluntary and usually involves less money for the injured worker because it is an immediate payment.

Unless it is stated in the Agreement as to Compensation and Order Approving Settlement, a settlement does not release the employer from the responsibility to pay future medical expenses for treatment of the injury.

Since the year 2000, the law specifies that settlement agreements for lump-sum payments of future income benefits which amount to more than $100 per week will not be approved by a judge, "unless there is reasonable assurance that the worker will have an adequate source of income during disability."

What if someone is killed on the job?

If an employee's death occurs within four years of a work-related injury, a lump sum payment is paid to the employee's estate. In 2000, this payment amount was raised to $50,000 for injuries occurring on or after July 14, 2000. The lump sum death benefit payment amount is adjusted annually and is determined by the date of injury, not the date of death. For injury dates between January 1 and December 31, 2002, the amount is $54,089.

The surviving spouse and certain dependents are also entitled to income benefits.

What assistance is there for the injured workers who can not return to their jobs?

Kentucky law provides retraining benefits for those who are unable to perform work for which they have previous training or experience, due to the effects of work related injuries. In addition to paying costs such as tuition and textbooks for up to 52 weeks, insurance companies may also provide financial assistance with the costs of transportation, lodging and meals. On a case by case basis, additional periods of training may be awarded.

After a claim has been filed, an award decided and the Administrative Law Judge determines that a vocational evaluation is necessary, injured workers are referred to the Department's Vocational Rehabilitation section. Evaluations are scheduled for the injured worker by the Department's staff members and are conducted at assessment centers located throughout the state.

Kentucky Assessment Centers

These evaluations consist of reviewing the injured employee's academic achievement levels, occupational aptitudes and interests. Typically, an evaluation takes a day to complete. Once the evaluation process is finished, the staff of the Department of Workers' Claims then reviews the evaluation results with the injured employee.

Assistance is provided to the injured worker to determine the retraining options available and to pursue a vocational goal that is compatible with the worker's academic and physical abilities.

YOU CAN CHOOSE TO WEAR ANOTHER HAT

Because of changes to the workers' compensation black lung law, there are many new education and training options available to miners who are awarded retraining incentive benefits ... you can go to college or you can go to truck driving or real estate school ... you can train to be a computer technician or a health care worker or any one of many other occupations. You can receive income benefits while you are in training and receive your education costs, plus possible bonuses upon completion.

See what opportunities exist!

Call the Department of Workers' Claims in Frankfort 1-800-554-8601 or

Louisville 1-866-874-0006	Madisonville 1-866-874-0005
Paducah 1-800-554-8603	Pikeville 1-800-554-8602

or visit the web site at dwc.state.ky.us

Classes are available all across the state!

For more information on post secondary educational programs in your area contact:

Kentucky Higher Education Assistance Authority
1-800-928-8926, www.khesa.org

Kentucky Community and Technical College System
1-877-528-2748, www.kctcs.net

Under this program, you can qualify for up to 17 weeks of GED or other remedial training if needed prior to the post secondary training. For information on GED and other adult education programs at a location close to you contact:

Kentucky Department for Adult Education and Literacy
1-800-928-7323, http://adulted.state.ky.us

Kentucky School Boards Association
1-800-372-2961, www.ksba.org

Labor Cabinet
Joe Norsworthy,
Secretary

Department of Workers' Claims
Larry M. Greathouse,
Commissioner

What do recent changes in the black lung law mean?

For Kentucky workers' compensation purposes, the presence of black lung (also known as coal workers' pneumoconiosis or CWP) is determined by interpretation of chest X-rays. The extent of benefits for black lung depends on the X-ray classification of the disease (Category 1, 2, 3 or complicated pneumoconiosis) and the degree of pulmonary impairment caused by black lung. Respiratory impairment is determined by pulmonary function tests administered by a physician, specifically the forced vital capacity test (FVC) and the forced expiratory volume in one second measurement (FEV1).

For Last Exposure Prior to 12/12/96: A miner with Category 1 black lung who has no respiratory impairment is entitled to retraining incentive benefits (RIB). This one-time benefit is equal to 50% of the permanent partial disability rate payable over 208 weeks. Retraining Incentive Benefits are payable for working miners only as reimbursement of expenses incurred while attending an approved job-training program. Benefits are paid directly to miners who leave the mining industry through no fault of their own.

ILO Category (x-ray)	Pulmonary Function PVC or FEV 1	Percent of Disability	Duration of Benefits
Category 1	80%-100%	RIB	104 weeks
Category 1	55%-79%	25%	425 weeks
Category 1	Less than 55%	50%	425 weeks
Category 2	80%-100%	25%	425 weeks
Category 2	55%-79%	50%	425 weeks
Category 2	Less than 55%	75%	520 weeks
Category 3	80%-100%	50%	425 weeks
Category 3	55%-79%	75%	520 weeks
Category 3	Less than 55%	100%	Lifetime *
Complicated Pneumoconiosis		100%	Lifetime *

**** Benefits terminate on the date the employee becomes eligible for normal old age Social Security benefits.***

An individual who is found to have Category 1 black lung with spirometric test values of 55%-79% of predicted normal values is declared 75% occupationally disabled. It must be shown that the respiratory impairment is the result of exposure to coal dust. An individual found to have Category 1 black lung with breathing capacity of less than 55% of predicted normal values, Category 2 black lung, or Category 3 black lung is presumed to be totally disabled. In these circumstances, benefits are paid for permanent total disability.

For Last Exposure on and after 12/12/96: Working miners may file claims, but they may not receive benefits while working. Income benefits for black lung with last exposure on December 12, 1996, or later are paid equally by the employer and the State Coal Workers' Pneumoconiosis Fund. The chart on page 30 shows the relationship among the X-ray diagnosis, pulmonary function, percentage of disability, and the duration of payment of benefits. Employees found to have Category 3 with severe breathing restrictions and those with complicated pneumoconiosis are deemed to have a permanent total disability.

What are the new retraining incentive benefits for qualifying miners?

The current law makes an effort to educate and retrain miners diagnosed with pneumoconiosis but who do not have severe breathing restrictions. Miners who qualify for black lung benefits may qualify for retraining under the new laws. This training can include earning a GED as well as other post secondary degrees or certificates. Retraining incentive benefits are available when a miner is diagnosed as Category 1 with no breathing impairment. Benefits are paid only while the employee is enrolled in a bona fide training or education program.

Full-time students (those attending classes for a minimum of 12 hours a week) receive RIB benefits at a rate of 66 2/3 % of the employee's average weekly wage, not to exceed 75 % of the state average weekly wage, for up to 104 weeks. Part time students (those attending classes for at least 6 hours a week) receive 33 1/3 % of the employee's average weekly wage, not to exceed 37 ½ % of the state average weekly wage for up to 208 weeks. Employees needing assistance obtaining a GED may be eligible for additional benefits.

Employees with a 25 % disability rating can elect to participate in retraining instead of receiving income benefits.

Retraining incentive benefits begin no later than the 30th day after the Administrative Law Judge's award becomes final. The employee may elect to defer benefits for up to one year. Benefits deferred longer than one year will lead to a week for week reduction in benefits for each additional week of deferral.

Employees 57 years of age or older on date of last exposure who are awarded Retraining Incentive Benefits may elect to receive income benefit payments for 425 weeks or until age 65 (whichever occurs first) instead of retraining incentive benefits. These benefits will equal 25% of 66 2/3 % of the employees' average weekly wage, not to exceed 75 % of the state average weekly wage.

Upon completion of a bona fide training or educational program, an employee is eligible to receive a payment of $5,000 if the program lasts between 12 and 18 months or $10,000 if the program lasts more than 18 months.

In addition to weekly benefits, the employer must pay tuition and material costs (not to exceed $5,000) directly to the educational institution conducting the training program.

What are the procedures for filing a coal workers' pneumoconiosis claim?

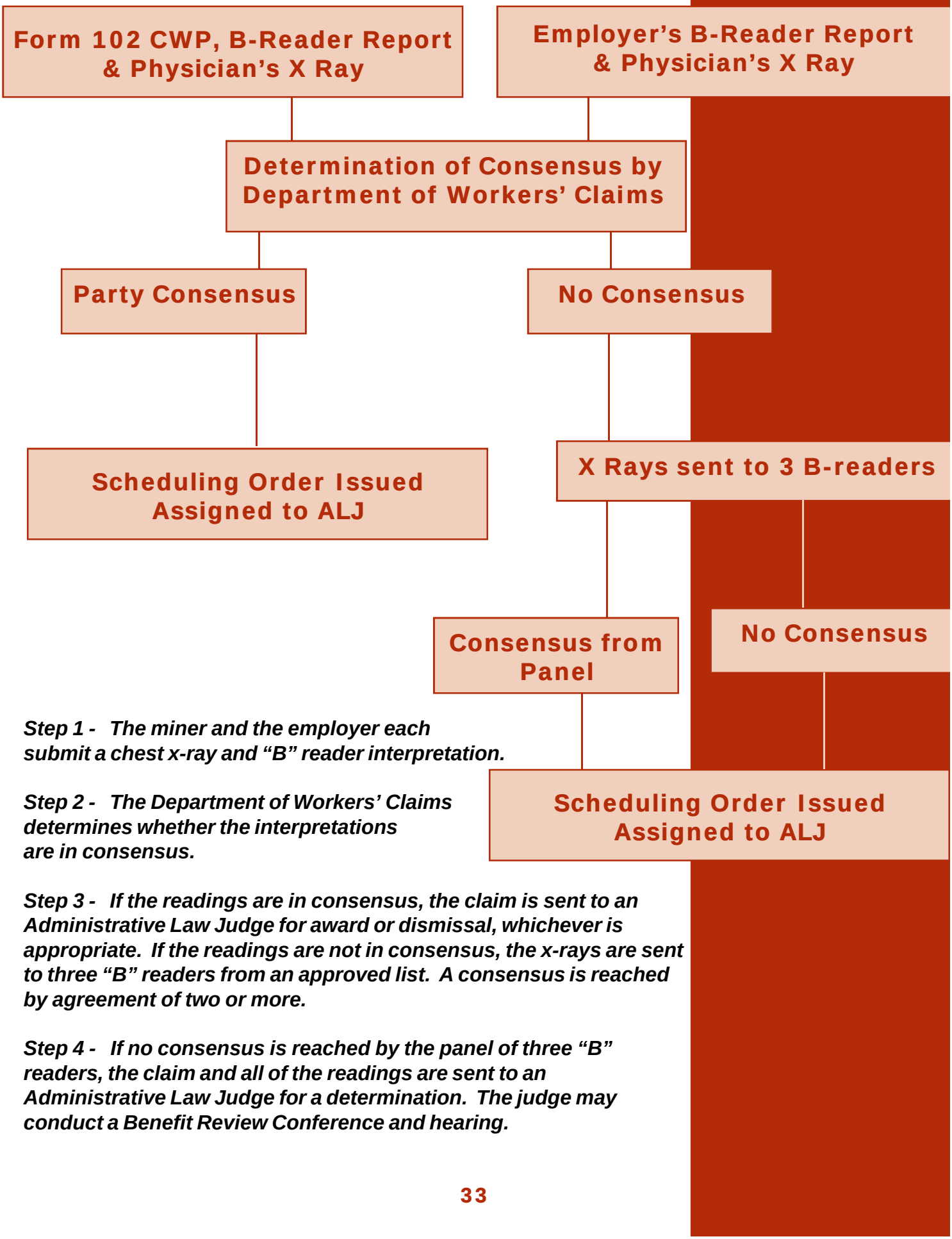
Extensive changes in the black lung claims process were made in 2002. The changes affect three classes of miners: those with a date of last coal dust exposure after July 14, 2000 and those miners with a last exposure of December 12, 1996 or later who want their claims reconsidered based upon the 2002 law. It also applies to those miners who did not file a claim.

The diagnosis of pneumoconiosis will be made on the basis of the interpretation of x-ray readings exclusively by "B" readers. "B" readers are physicians certified as being proficient in the x-ray diagnosis of pneumoconiosis by the National Institute of Occupational Safety and Health.

Under this procedure, the miner must file with his Form 102 (Application for Resolution of Occupational Disease Claim) an x-ray and the "B" reader's interpretation. Pulmonary function studies must also be submitted if breathing impairment due to black lung is claimed. The spirometric chart or tracings must be filed with the breathing report.

Within 45 days of the scheduling order assigning the claim to an Administrative Law Judge, the employer may have the miner examined and another chest x-ray made and breathing test done. The Commissioner then determines whether there is 'consensus' between the parties' x-rays. Consensus means agreement of at least two doctors on major category of disease as well as within one minor category based on the ILO 12-point scale. For example, an interpretation of 1/1 would be in consensus with a reading of 1/2. However, a reading of 2/1 would not be in consensus with a reading of 2/3.

This flow chart shows the consensus reading process



Step 1 - The miner and the employer each submit a chest x-ray and "B" reader interpretation.

Step 2 - The Department of Workers' Claims determines whether the interpretations are in consensus.

Step 3 - If the readings are in consensus, the claim is sent to an Administrative Law Judge for award or dismissal, whichever is appropriate. If the readings are not in consensus, the x-rays are sent to three "B" readers from an approved list. A consensus is reached by agreement of two or more.

Step 4 - If no consensus is reached by the panel of three "B" readers, the claim and all of the readings are sent to an Administrative Law Judge for a determination. The judge may conduct a Benefit Review Conference and hearing.

What is involved in reopening a black lung claim?

For awards and settlements made prior to December 12, 1996, the opportunity to reopen ended four years after, or on December 12, 2000. However, most black lung claims under the 1996 law have until December 12, 2003 to file a motion to reopen on previously filed claims, or to file a new claim if no claim was ever filed.

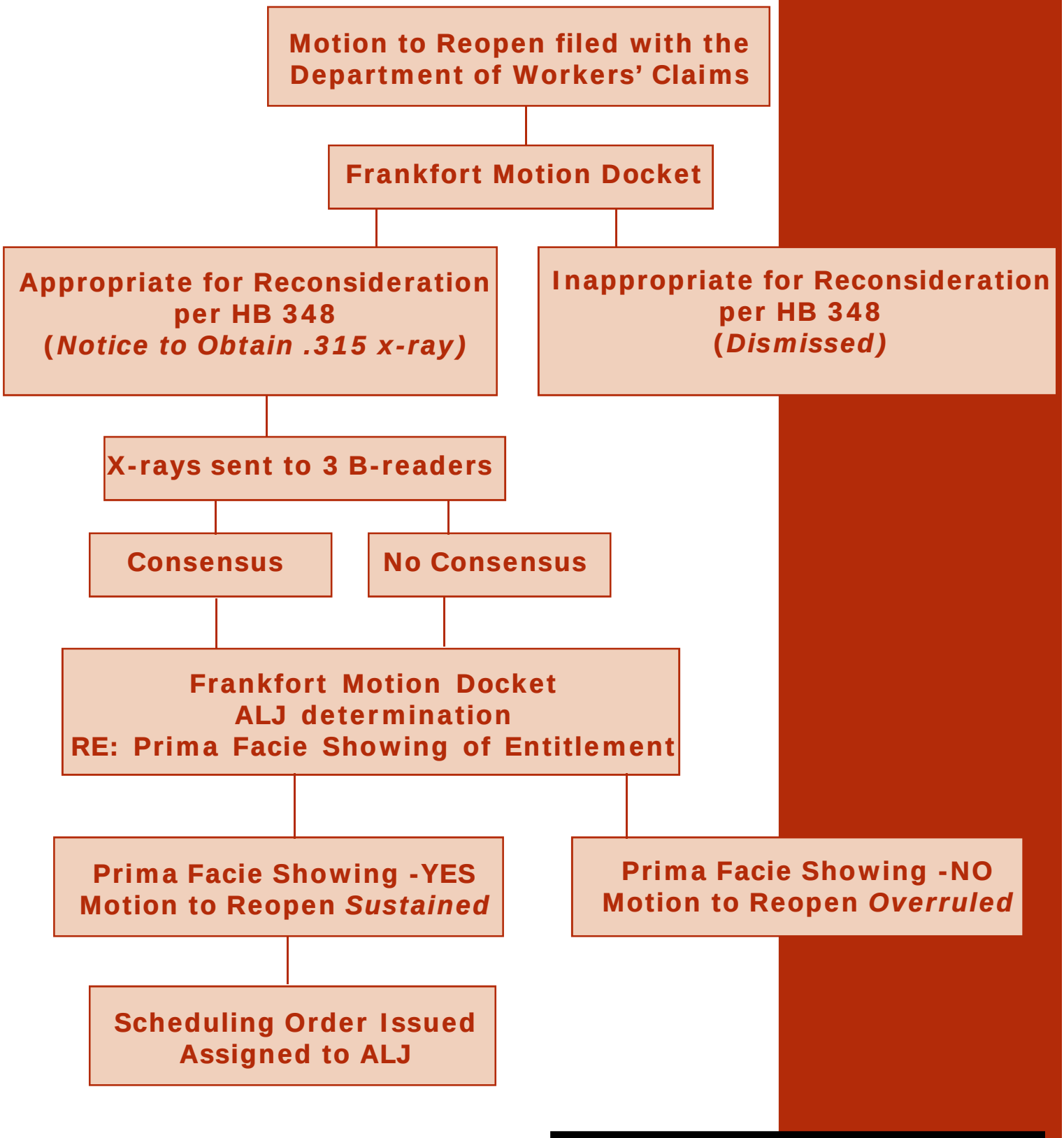
There are new procedures involved for certain individuals seeking reconsideration of a coal workers' pneumoconiosis claim. These include miners last exposed to coal dust after December 12, 1996 whose claims are now closed and were dismissed for medical eligibility reasons. It also includes those claims, who were exposed to dust after December 12, 1996 who did not file a claim and those claims whose last exposure was before that date but whose claim was denied on medical grounds after having had a university evaluation. A miner wishing to have his/her previously-filed claim reconsidered would file a Motion to Reopen which should be accompanied by:

1. A current medical release (Form 106);
2. An affidavit which states:
   a) last date of on-the-job exposure to coal dust
   b) that the claim is appropriate for reconsideration
   c) that the claim was not previously dismissed based on anything other than failing to meet medical eligibility standards
   d) If last exposure was prior to December 12, 1996, the previous claim was dismissed upon a finding that the miner did not prove the presence of coal workers' pneumoconiosis through x-rays.
3. If an award was granted under previous law, a statement of the amount awarded and benefits actually received and a copy of the previous award or, if settled, a copy of Form 110 and any accompanying documents.
4. Updated work history (Form 104) and medical history (Form 105)

Once the Motion to Reopen is filed and the Administrative Law Judge determines that all requirements are met, the Commissioner shall obtain the x-ray from the evaluating medical school. This x-ray will be forwarded to three B readers in order to reach a consensus. The university B reader who interpreted the x-ray in the original claim is excluded from participating in this consensus panel.

Within 15 days of receiving the three B-reader's reports, the Commissioner shall notify all parties as to whether consensus has been reached and then assign the case to an Administrative Law Judge. If consensus is reached, the parties have 30 days to notify the Department of Workers' Claims of their intent to challenge.

If the judge finds that there is an entitlement to greater benefits, the Commissioner shall schedule a pre-hearing conference and issue a scheduling order for the presentation of proof. However, no additional x-ray readings or pulmonary function studies shall be submitted as evidence.



CWP Reopenings Authorized by HB 348

Medical Care

Kentucky employers are required to pay reasonable and necessary medical expenses that employees incur for treatment of work-related injuries and illness. This includes the services of medical doctors, chiropractors, hospitals and other licensed providers.

How is a designated physician chosen?

The injured employee has the right to choose the treating physician without interference from the employer. This physician, depending on the nature of the injury or illness may be a general practice physician, surgeon, psychologist, optometrist, dentist, podiatrist, osteopath or chiropractor. The designated physician is the primary treating physician and is responsible for referring the employee to additional providers as necessary. The employee has the one-time right to change the designated physician. Additional changes require permission from the employer or insurance carrier or the approval of an Administrative Law Judge.

Within ten (10) days following the notice of a work related injury the employer or insurance carrier must send Form 113 (Notice of Designated Physician) to the employee who then has ten (10) days to complete and return the form.

After the form is completed the insurance carrier will provide the injured employee with a printed card indicating:

- Employee name, social security number, date of birth and the date of the work related injury or exposure.
- The name and telephone number of the physician selected by the employee.
- The name and telephone number of the insurance carrier (who is responsible for payment).
- General information concerning Form 113 on the reverse side of the card.

The employee must present this card when seeking additional medical services for the work-related injury.

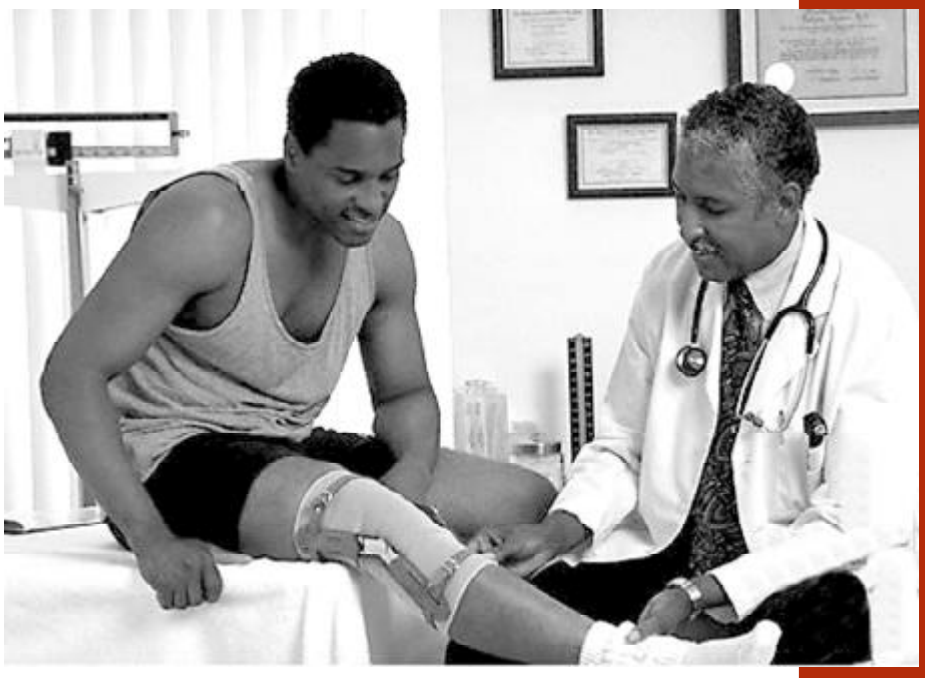
Are Co-Payments and Balance Billing permitted?

The employer of an injured employee is required to pay the cost of all reasonable medical treatment necessitated by the work related injury or illness, including co-payments. **It is unlawful to require employees to pay co-payments for the treatment of work related injuries or illness.**

The Department of Workers' Claims has adopted fee schedules that set forth the amount which physicians, hospitals and pharmacists may charge for their services. Medical providers are prohibited from engaging in "balance billing' by charging employees separately for amounts in excess of those set forth in the medical fee schedules.

Will an employee be reimbursed for expenses incurred as part of obtaining medical treatment?

Employees are entitled to reimbursement for expenses paid in the process of receiving medical treatment, including reasonable travel expenses and out of pocket payment of prescriptions and similar items. The employee must submit the request for reimbursement to the carrier or self-insured employer within 45 days of incurring the expense. Employees may obtain the Form 114 from the insurance carrier or from the Department of Workers' Claims to claim out of pocket medical and travel expenses.



Why are medical evaluations ordered and where are they conducted?

To resolve workers' compensation claims, other than black lung claims, the Commissioner or an Administrative Law Judge may direct that physicians at either the University of Louisville Medical School or the University of Kentucky Medical School evaluate an employee. If an employee does not submit to the evaluation, the claim will be delayed and benefits may be denied.

Who is responsible for expenses incurred while obtaining a medical evaluation?

At least one (1) week prior to a scheduled medical evaluation, the employer is required to send the employee travel expenses for attending the evaluation. Mileage is paid at the rate of thirty-two cents ($.32) per mile for the distance from the employee's home city to the medical evaluation site.

What is the purpose of the Utilization Review and Medical Bill Audit procedures and are they required?

Insurance carriers, individual self-insured employers and group self-insured employers must have certain medical cost containment programs in place, such as utilization review and medical bill audit programs in place that have been approved by the Department of Workers' Claims.

Utilization review is an evaluation of the medical necessity and appropriateness of treatment and services. Medical bill audit is an examination of medical bills to assure compliance with the adopted fee schedules. No medical service dispute may be filed before the utilization review process is complete. Utilization review for employers who have approved managed care programs is conducted by the managed care organization. Utilization review is required when:

- Medical bills exceed $3,000 per employee
- An employee misses thirty (30) days of work due to the injury
- A medical provider requests pre-certification
- A treatment plan is required.

Only licensed medical personnel may conduct utilization review, and the process must grant reconsideration of an initial denial and provide notice to the employee. Utilization review is not intended to address the issue of the work-relatedness of the condition being treated.

Managed care has been authorized for the treatment of work-related injuries and diseases since April 4, 1994. Employees subject to managed care plans are required to choose "gatekeeper" physicians from the managed care plan network.

A managed care organization must demonstrate that it meets standards established by the Department of Workers' Claims in order to be approved. Managed care programs must have sufficient specialty providers to treat common work-related conditions. If a plan physician recommends surgery, employees may obtain a second opinion from an outside physician at the expense of the employer.

Employees may also obtain medical services outside the plan when:

- Emergency care is not available through the plan;
- A plan physician makes a referral;
- Necessary treatment is not available through the plan;
- Treatment with a non-network physician was begun prior to implementation of the plan.

Are injured employees required to stay within their managed care system for treatment of a work related injury/ illness?

Claims Resolution

What services does the Division of Ombudsmen and Workers' Compensation Specialists offer?

The Division of Ombudsman and Workers Compensation Specialist Services includes the Ombudsmen and Workers Compensation Specialist Branches, and the Medical Services Branch which includes both the Medical Cost Containment and Rehabilitation Sections. This division is essentially the constituent services group. Ombudsmen and workers compensation specialists are trained in workers compensation law and procedure and answer questions on a variety of workers compensation topics. They also attempt to resolve conflicts through intervention. During the time that an employer or its insurance carrier voluntarily pays medical bills and income benefits for work-related injuries or occupational diseases, there will be few disputes. When payment of income benefits or medical services are in dispute, then parties may contact this staff for assistance. Many of the requests for assistance are resolved to all parties' satisfaction through open communication. Although workers make the most requests for assistance, Department of Workers claims specialists and ombudsmen are equally available to employers, medical providers and insurance carriers.

If the issues cannot be resolved, then a claim may be filed. While the Department strongly recommends that parties seek the assistance of any attorney to file a claim, specialists can assist the unrepresented worker in completing the claim forms and in gathering materials needed for filing the claim.

This Division also houses the medical cost containment programs such as utilization review, university or B-reader consensus evaluations, managed care, and the hospital and medical fee schedules. Additionally vocational rehabilitation functions, both for the new black lung retraining process as well as regular retraining evaluation & assistance for injuries and other occupational diseases, are handled by division staff. These various programs are discussed elsewhere in this manual.

What is the Voluntary Mediation Program?

The Department of Workers' Claims offers workers' compensation mediation services to speed the resolution of claims and expedite the delivery of benefits to injured employees. Intervention by a neutral third party may result in quick, low-cost dispute resolution. Mediation services are provided at the request of a party to a dispute and begin after other parties agree to participate. If a claim is already on file with the department, the request for mediation must be in writing. The mediator assigned to the dispute will attempt to achieve resolution through telephone conference calls.

Requests for mediation can be made by phone, fax, or in writing. Phone 1-800-554-8601, send a fax (502-564-9533), or write to: Division of Ombudsmen and Workers' Compensation Specialist Services, 657 To Be Announced Avenue Frankfort KY 40601. If necessary, a face-to-face mediation conference may be scheduled at one of the Department of Workers' Claims hearing sites.

The request for or participation in mediation services does not affect time limits established by applicable statute of limitations for filing of claims.

What are the time limits for filing claims?

A written claim for workers' compensation benefits must be filed with the Department for Workers' Claims within two (2) years of the date of injury or last voluntary payment of disability income benefits, whichever is later. Note that payment of medical expenses does not extend the time for filing a claim.

Occupational disease claims must be filed within three (3) years after diagnosis or after symptoms first appear which are sufficient to inform the employee of the disease, whichever is earlier. A claim may also be filed within three (3) years after death caused by an occupational disease. The maximum period to file most occupational disease claims is five (5) years after the employee was last exposed to the occupational hazard responsible for causing the disease.

The changes made to the law by House Bill 348 in 2002 allows miners with injurious exposure between December 12, 1996 and July 15, 2002 to file a claim on or before December 12, 2003 if a claim has not been filed. Closed claims may be reopened on medical eligibility standards.

Special rules apply to human immunodeficiency virus (AIDS), asbestosis, and conditions caused by radiation exposure. AIDS claims must be filed within five (5) years after exposure to the virus. The time to file a claim involving an asbestos or radiation related disease is twenty (20) years after last exposure, but filing must occur within three (3) years of when a worker knows of the development of the disease.

Is it necessary to have an attorney to file a claim?

Due to the complexity of the claims process, most injured workers hire an attorney to file a workers' compensation claim for them. Employees may choose to represent themselves, but they will be held to the same standards as attorneys who present workers' compensation claims. Workers' compensation specialists from the Department can assist a claimant who is not represented by an attorney in completing claim forms, and in gathering information needed for a claim. However, these specialists cannot act as a person's legal representative.

Only attorneys licensed to practice law in Kentucky may represent participants in workers' claims proceedings. Attorney fees for injured workers are on a contingency fee basis, which means that the injured worker must reach an agreement of payment or receive an award before fees are payable to the attorney.

Are there limits on attorney fees?

For attorney/client contracts made on or after July 14, 2000, there is a maximum fee an injured worker's attorney can charge. For the first $25,000 of the award, an attorney can charge up to 20%; for the next $10,000 of the award, the charge can be 15% and 5% can be charged for the remainder of the award, not to exceed $12,000.

How do I file a claim?

A claim application contains basic information identifying the employee, the employer and describes the nature and cause of the work-related injury or disease. The application must be filled out completely, typed, notarized and then filed with the Department of Workers' Claims.

There are three types of claim forms:

Form **101** - Application for Resolution of **Injury** Claim
Form **102** - Application for Resolution of **Occupational Disease** Claim
Form **103** - Application for Resolution of **Hearing Loss** Claim

In addition to the appropriate claim form, the employee must also complete and file the following:

Form **104** - Plaintiff's Employment History
Form **105** - Plaintiff's Chronological Medical History
Form **106** - Medical Waiver and Consent
Form **115** - Social Security Release Form

(Not required for Form 101 applications)

Also, a medical report that establishes a causal relationship between the work-related events and the medical condition and documentation of pre-injury and post-injury wages.

The employee and any witnesses (if applicable) must sign and date these forms.

What happens after a claim is filed?

Listed below are the step by step processes that are followed once a claim has been properly filed.

1. Once the claim application has been filed with the Department of Workers' Claims, the employee, employer and the employer's insurance company will be notified that the claim has been assigned to an Administrative Law Judge. This notification of assignment letter will also include information regarding the time frame for presentation of proof.

2. Within forty-five (45) days of the date of this notice, the employer and/or their insurance company is required to file with the department a **Notice of Claim Denial or Acceptance**. This notice should state specifically the issues of the claim that are acknowledged and those that are denied.

3. After a claim has been assigned to an Administrative Law Judge, there are 60 days during which both sides can submit proof (evidence such as **medical reports** and **depositions**). After the first 60 days passes, only the defendants can submit proof during the next 30 days. After the defendants' 30-day period, then only the plaintiff can submit proof for the next 15 days.

4. A scheduling order is mailed by the Department of Workers' Claims to all involved parties; this notification includes the date, time and location of the benefit review conference. Although the benefit review conference is informal and no evidence is presented or testimony offered, all parties should attend. The benefit review conference is scheduled for the purpose of defining and narrowing the issues, discussing a settlement and considering other relevant matters that may aid in the disposition of the case.

5. If no settlement is reached during the benefit review conference, the Judge will then schedule a hearing. Usually held within two weeks of the benefit review conference, the hearing is formal and on the record, with witness testimony, etc.

6. After the hearing, the Administrative Law Judge may have the parties file briefs, which sums up their side of the case. The Judge has sixty (60) days following the hearing to issue a written decision.

7. Within 14 days from the date of the filing of the judge's award, order or decision, any party may file a **Petition for Reconsideration** of the award, order or decision. This petition shall clearly state the reasons and argument for reconsideration. Once the judge has ruled on the Petition for Reconsideration, then any party can appeal that decision to the Workers' Compensation Board.

How is an appeal filed?

Once the Administrative Law Judge issues an award, an order or decision, either party may appeal to the Workers' Compensation Board. The deadline for filing an appeal is 30 days after the judge files the final decision. However, no additional evidence may be introduced and the Board shall not substitute its judgment for that of the judge.

The Board's review is limited to determining whether or not:

1) the administrative judge acted without or in excess of his/her powers;
2) the award, order or decision was procured by fraud;
3) the award, order or decision does not conform to the workers' compensation law;
4) the award, order or decision is clearly wrong on the basis of the reliable material evidence contained in the whole record, or
5) the award, order or decision is arbitrary and/or shows an abuse of discretion

If the Administrative Law Judge was presented with conflicting evidence, the Workers' Compensation Board will uphold the decision as long as any portion of the evidence supports the judge's decision.

The Workers' Compensation Board shall rule on an appeal of a decision of an Administrative Law Judge no later than 60 days following the date on which the last appeal brief was filed. The Board shall enter its decision affirming, modifying or setting aside the award, order or decision or return it to the Administrative Law Judge for further proceedings to conform to the direction of the Board.

A decision agreed upon by any two of the three members of the Workers' Compensation Board shall constitute a decision of the Board.

Appealing a decision made by the Workers' Compensation Board will take the claim into the Kentucky appellate courts. These courts grant deference to Board decisions and will affirm the decisions made by the Workers' Compensation Board unless it has made a significant misinterpretation of the law.

Can a claim be reopened?

Generally, a workers' compensation claim can be reopened by a filing of a **Motion to Reopen**. This motion can be made by any party or by an Administrative Law Judge's own motion. Reopening or review of the award or order must be based on grounds that include:

- Fraud
- Newly discovered evidence
- Mistake
- Change in disability shown by objective medical evidence or worsening or improvement of the impairment due to a condition caused by the injury since the date of the award or order

No claim can be reopened more than four (4) years following the date of the original award or order granting or denying benefits. Also, no party may file a Motion to Reopen with one (1) year of their previous motion to reopen.

The four (4)-year limitation does not apply to reopenings regarding medical issues, a return to work after receiving a total disability award, fraud, or increase in or reduction of benefits to conform with the employee's current work status under impairment model awards for **injuries occurring after December 12, 1996**.

Reopening a claim shall not affect any benefit payments already awarded or ordered and any change in the amount of benefit payments shall be ordered only from the date of the filing of the Motion to Reopen.

No employer or carrier shall suspend benefit payments while a claim is in the reopening process, unless so ordered by an Administrative Law Judge.

Glossary

AMA impairment rating

Used by treating physician to describe percentage of body functional impairment caused by injury or occupational disease; determined by the latest edition of the American Medical Association's *Guides to the Evaluation of Permanent Impairment.*

Average Weekly Wage

In most instances an employee's average weekly wage is calculated by using the highest calendar quarter of earnings for the year before the injury occurred. Earnings for the highest quarter are divided by thirteen (13) and the result is the employee's average weekly wage. Overtime is included, but only at regular hourly wage rates. Earnings for the highest quarter are then divided by 13; the result is the employee's average weekly wage.

B reader

Physician certified by the National Institute of Occupational Safety and Health as proficient in the use of a special classification system for x-ray interpretation.

Benefits

Medical treatment, rehabilitation and partial wage replacement provided to injured workers under the Workers' Compensation Act.

Claim

In Kentucky, not every work-related injury is a claim; only cases in which there are disagreements that cannot be resolved (i.e. contesting payment of benefits, a question of the extent of disability) become claims.

Coal Workers' Pneumoconiosis (CWP)

A respiratory disease caused by inhaling coal dust for prolonged periods; also known as Black Lung Disease.

Consensus reading

When the B readers who are interpreting the chest x-rays submitted with a coal workers' pneumoconiosis claim make the same finding in a major category and within one minor category of the ILO x-ray scale; new law provides for multiple interpretations in effort to reach consensus.

Defendant

The person/employer required to answer in a lawsuit or claim.

Acronym for Electronic Data Interchange. Used by insurance carriers and self-insured employers to electronically report workers' compensation data to the Department of Workers' Claims as required by law.	**EDI**
The initial report of a workplace injury that involves lost time; the employee reports to employer, the employer to carrier and the carrier reports electronically to the Department of Workers' Claims.	**First Report of Injury**
The loss of a body part or the total or partial loss of use of a body part.	**Impairment**
Exempt from workers' compensation insurance; a worker who determines own work schedule and uses own tools/vehicle; examples include postal carrier, construction worker, farm laborer, taxi driver.	**Independent contractor**
Provides benefits to employees or their dependents in case of job-related injuries and/or fatalities and to those who contract or develop diseases due to workplace exposure.	**Workers' Compensation Act**
Informal dispute resolution process where a neutral third-party attempts to assist the parties in reaching a mutually agreeable settlement in lieu of the claim being decided by a judge.	**Mediation**
A review of medical bills for services provided to determine if the bills comply with the fee schedule.	**Medical bill audit**
A listing of the appropriate maximum charges for medical services provided by physicians to injured workers.	**Medical fee payment schedule**
A physician or other person who provides medical treatment.	**Medical provider**
A condition caused by an exposure to a hazard in the workplace; usually develops over a lengthy period of time; a disease arising out of and in the course of employment.	**Occupational Disease**

Permanent Partial Disability (PPD)	Permanent partial disability benefits are payable when "an employee ... has a permanent disability rating but retains the ability to work."
Permanent Total Disability (PTD)	Permanent total disability benefits are payable when "an employee has a complete and permanent inability to perform any type of work as a result of an injury".
Petitioner	The person filing the claim, initiating the lawsuit; at the appeals level.
Plaintiff	The person filing the claim or initiating the lawsuit.
Pulmonary Function Tests (PFTs)	Medical breathing tests which are used to detect and measure breathing impairment. Used mainly in black lung cases, a complete PFT consists of three parts: spirogram, lung volume measurements and diffusion capacity test.
Respondent	The person/employer having to respond to a claim or lawsuit; at the appeals level
Retraining Incentive Benefits (RIB)	Offered to miners diagnosed with coal workers' pneumoconiosis but with no breathing impairment, many opportunities exist to educate and retrain while receiving partial wage replacement benefits.
Self-insurance	Self-insured employers pay their own workers' compensation losses directly and do not carry primary insurance coverage. Employers may join together and form associations known as self-insurance groups to insure their employees. Stringent financial requirements of self insured employers are necessary. The privilege to self insure is granted by the Department of Workers' Claims.

Settlement

An agreement by which parties having disputed matters between them reach or ascertain what is coming from one to the other. This resolution may be reached with or without a hearing of all or some of the issues to a dispute.

State average weekly wage

Announced annually by the Cabinet for Workforce Development; used as a guide in determining amount of injured worker's partial wage replacement benefits.

Temporary Total Disability (TTD)

Temporary total disability (TTD) benefits are paid during the period in which the worker is recovering from an injury or disease and is unable to return to work.

Unfair claims settlement practice

Standards placed on insurance carriers in their dealings with an injured worker from time of injury to resolution of a claim as prescribed by statute and regulations.

Uninsured Employers Fund

Fund established to pay workers' compensation benefits to injured employees of uninsured employers that default in payment of benefits.

Utilization review

Evaluation by the payment obligor of the medical appropriateness and necessity of medical care and services for the purpose of recommending payments for compensable injuries or diseases.

Vocational Rehabilitation

Retraining opportunities offered to an injured worker when, as a result of the work-related injury, the worker is unable to perform work for which he/she was previously trained.

Workers' Compensation Benefit Payment Rates (Maximum, 1980-2002)

Year	Total Disability	Permanent Partial Disability (PPD)	Retraining Incentive Benefits (RIB)	Total Disability (Minimum)
2002	$550.66	$413.00	$413.00	$110.13
2001	$530.07	$397.55	$397.55	$106.01
2000	$509.03	$381.77	$381.77	$101.81
1999	$487.20	$365.40	$365.40	$97.44
1998	$465.36	$349.02	$349.02	$93.07
1997	$447.03	$335.27	$167.64	$89.41
1996	$415.94	$311.96	$155.98	$83.19
1995	$415.94	$311.96	$155.98	$83.19
1994	$415.94	$311.96	$155.98	$83.19
1993	$394.39	$295.79	$147.90	
1992	$380.00	$285.00	$142.50	
1991	$362.03	$271.52	$135.76	
1990	$353.24	$264.93	$132.47	
1989	$343.02	$257.27	$128.64	
1988	$330.53	$247.90	$123.95	
1987	$322.19	$241.64	$120.82	
1986	$316.54	$237.41		
1985	$304.80	$228.60		
1984	$294.87	$221.15		
1983	$277.66	$208.25		
1982	$254.33	$190.75		
1981	$233.26	$162.74		
1980 (7/15 and after)	$216.99	$162.74		

Notes

PRINTED WITH STATE FUNDS

No individual in the United States shall, on the grounds of race, color, religion, sex, national origin, age, disability, political affiliation or belief, be excluded from participation in, or denied benefits of, or be subjected to discrimination under any program or activity under the jurisdiction of the Kentucky Labor Cabinet.

This agency does not discriminate on the basis of race, color, national origin, religion, age or disability in employment or provision of services.